MDR: M4-02-3864-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 2-12-02.

   b. The request was received on 6-6-02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFA(s)
   c. EOB/TWCC 62 forms/Medical Audit summary
   d. Medical Records
   e. Example EOB from another Carrier
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. HCFA(s)
   c. Medical Audit summary/EOB/TWCC 62 form
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14-day response to the insurance carrier on 8-5-02. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 8-6-02. The response from the insurance carrier was received in the Division on 8-15-02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 7-22-02

   "We are requesting an additional amount be considered for CPT 64999-51. This code represents the second level of a two level IDET (IntraDiscal Electro Thermal therapy), which was approved by fax with approval number 75124 on February 24, 2002. Guidelines state that reimbursement for this code is based on presentation of documentation. We are also requesting an additional amount be considered for CPT 99070…. The two level IDET requires the use of two (2) catheters at a cost to the physician of approximately $1800."

2. Respondent: Letter dated 8-14-02

   "The disputed issue concerns healthcare services provided by Provider on February 12, 2002. Provider provided IDET to Claimant and billed Self-Insured $11,250.00 for this service. Self-Insured paid Provider $2,340.00 on March 22,2002 with check no. 1751607 and $3,400.00 on May 9, 2002 with check no. 1769783. Self–Insured incorporates by reference its Self-Insured's exhibit No. A as documentation explaining why $5,740.00 is fair and reasonable reimbursement designed to ensure the quality of medical care and to achieve effective medical cost control. If the Commission orders reimbursement for unsubstantiated medical cost, then it will be adopting guidelines and policies within its decision making powers that are not fair and reasonable and that do not achieve effective medical cost control…. While Provider billed under a DOP CPT Code, the Medical Fee Guidelines do provide some evidence of a fair and reasonable amount. As discussed in Self-Insured's Exhibit No. B, CPT Codes 62287 and 72295 represent similar services with MARs well below the amount billed by Provider. Provider has not justified why charging amounts significantly more is fair and reasonable."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 2-12-02.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per conversation with Provider representative on 3-5-03, verification was received that the total amount paid for CPT Code 64999-51 was $1000.00 leaving a balance of $3,100.00; total amount paid for CPT Code 99070 was $1,300.00 leaving a balance of $1,300.00.

5. The Carrier denied the billed services as reflected on the EOBs as, "M – NO MAR SET BY TWCC-REDUCED TO FAIR AND REASONABLE IDET; N – NOT APPROPRIATELY DOCUMENTED INSUFFICIENTLY IDENTIFIED OR QUANTIFIED NO DOCUMENTATION RECEIVED TO SUPPORT LEVEL OF SERVICE BILLED – PLEASE SUBMIT A COPY OF THE INVOICE IS NEEDED TO

REVIEW THIS CHARGE".

7. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
2-12-02	64999-51	$4,100.00	$1,000.00	M	DOP	MFG: General Instructions (III) (VI); TWCC Rule 133.307 (g) (3) (D); CPT Descriptor	CPT Code 64999-51 is a DOP procedure and as such there is no maximum allowable fee for this code. The Carrier has denied the disputed CPT Codes as "M". The carrier has reimbursed the provider $1,000.00 out of $4,100.00 for the second level of an IDET procedure. The law or rules are not specific in the amount of evidence that has to be submitted for a determination of what constitutes a fair and reasonable fee. However, pursuant to Rule 133.307 (g) (3) (D), the requestor must provide documentation that discusses, demonstrates and justifies the payment requested. Insufficient evidence was submitted to support that the provider's billed amount was fair and reasonable. No additional reimbursement is recommended.
2-12-02	99070	$2,600.00	$1,300.00	N	DOP	MFG General Instructions (III) (IV) & (VI); Surgery Ground Rules (V); CPT Descriptor	CPT Code 99070 is a DOP procedure and as such there is no maximum allowable fee for this code. The HCFA 1500 reflects that the services were performed in a doctor's office. Surgery Ground Rules (V) states "In order for a doctor's office to qualify for facility reimbursement for surgical procedures performed in a doctor's office, the office shall meet the following requirements; 1. a complete and routinely checked crash cart; 2. a registered nurse, CRNA, or doctor dedicated to the 'facility' room; 3. a separate observation or recovery room; 4. patient monitoring equipment, including EKG and pulse oximetry equipment; and 5. support staff and equipment to ensure that the care received by the patient is the same as that which would have been received in an ambulatory surgical center or in the outpatient surgical ward of a hospital." No documentation was noted in the dispute packet to support that the above requirements were met. Per GI, (III) (A) (3), "Time required to perform the service or procedure;" is required for DOP procedures. The operative report does not contain the time it took to complete the procedure. The provider has billed for services performed in a doctor's office without utilizing the appropriate modifiers, as required by SGR (V) (B). No additional reimbursement is recommended.
Totals		$6,700.00	$2,300.00				The Requestor **is not** entitled to additional reimbursement **.**

The above Findings and Decision are hereby issued this 05th day of March 2003.

Lesa Lenart
Medical Dispute Resolution Officer
Medical Review Division